Clear Form Entries

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

Rehabilitation Supports Screening & Referral Form

INSTRUCTIONS: Complete all sections below. A referral to the Lead Clinical Staff (or Life Skills Specialist) should only be made if a "yes" response is made for <u>all</u> items under 3, 4 & 5 below.

Consumer's Full Name: _____ DOB: _____/_____/_____

Medicaid #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ SSN: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

1) The consumer receives services through DDSN:

☐ Mental Retardation Division ☐ Autism Division ☐ Head & Spinal Cord Injury Division

☐ Other Specify (ex. High Risk Infant): _____

2) The consumer is:

☐ Currently in school

☐ Receiving Community Long Term Care (CLTC) Elderly and Disabled Waiver Services*

☐ Receiving HASCI Waiver Services*

☐ None of the above

* If receiving CLTC or HASCI Waiver Services explain why waiver services will not meet the person's needs:

_____

NOTE: If receiving CLTC Elderly and Disabled Waiver Services, notification to CLTC case manager <u>must be made prior</u> to receiving rehabilitation support services.

3) The consumer has expressed a need to develop, retain, or restore an optimal level of functioning in one or more of the following skills: Self-Care, Community Living Skills, Psycho-Social and/or Medication Management / Symptom Reduction:

☐ Yes ☐ No

4) The consumer would like to develop an enhanced capacity for personal independence essential for successful community living:

☐ Yes ☐ No

5) The consumer meets the following Rehabilitation Support eligibility requirements:

☐ Yes	☐ No	Meets DDSN eligibility criteria
☐ Yes	☐ No	Is a Medicaid recipient
☐ Yes	☐ No	Is not enrolled in the MR/RD Waiver
☐ Yes	☐ No	Does not reside in an Intermediate Care Facility for the Mentally Retarded or Nursing Home
☐ Yes	☐ No	Is approved to receive Rehabilitation Support Services by their Service Coordinator or Early Interventionist with authorization from the home board provider

_____ _____

Signature of Service Coordinator/Early Interventionist Date

_____ (_____) _____

Provider of Service Phone

LCS USE ONLY

SERVICE AWARDED: ☐ Yes ☐ No (explain: _____) ☐ Added to Waiting List

LCS Signature: _____ Date: _____

RS Form 1 (8/04)